**Affix your recent self**

**3x4cm photograph**

**In this box.**



**APPLICATION FORM - SCHOLARSHIP**

**FOR MASTER AND DOCTORAL PROGRAM**

**AT FACULTY OF MEDICINE, PUBLIC HEALTH AND NURSING**

**UNIVERSITAS GADJAH MADA**(PLEASE TYPE, DO NOT WRITE)

I am applying for:

 Master in Public Health

 Master in Clinical Medicine

 Master in Biomedical Sciences

 Master in Medical and Health Professions Education

 Master in Tropical Medicine

 Master in Nursing

 Master in Health Policy and Management

 Doctor in Medical and Health Science

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| **PERSONAL INFORMATION** | | | | | | |
| Complete the information | | | | | | |
| **Name:** (similar to passport/ID) |  | | | | | |
| **Citizenship:** |  | | | | | |
| **Place of birth:** |  | | | | | |
| **Date of birth :** |  | | | | | |
| **Mailing Address\* :** |  | | | | | |
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|  |  | | | | | |
|  | **City:** |  | | **Province:** | | |
|  | **Country:** |  | | **Zip Code:** | | |
| **✆Home:** |  | | **✆Mobile-phone:** | |  | |
| **E-mail:** |  | | | | |  |
| **Previous Educational Background** |  | | | | | |
| **University** |  | | | | | |
| **Work Address\*:** |  | | | | | |
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|  |  | | | | | |
|  | **City:** |  | | **Province:** | | |
|  | **Country:** |  | | **Zip Code:** | | |
| **✆Office :** |  | | **Fax :** | | |  |
| **E-mail:** |  | | | | |  |

\* Provide the current address, if it is different than the ID. DO NOT translate the address into English.

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| **STANDARDIZED TEST SCORES** | | | |
| Attach a photo copy of each test. Test results should not be older than 2 years. | | | |
| **Test** | **Score** | **Date taken** (dd/mm/yy) | **Location** |
| Certificate of English language proficiency test results  TOEFL /IELTS  International |  |  |  |
| Institutional |  |  |  |
| Grade Point Average |  |  |  |
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| **SCHOLASTIC DISTINCTIONS/HONORS** | |
| Start with the most current one. | |
| **Date** (dd/mm/yy) | **Distinction/Honors** |
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| **PROFESSIONAL HISTORY\*** | | | |
| List your work experience since university graduation. Start with the most current one. | | | |
| **Dates (To–From)** (Including Months) | **Position** | **Institution/Company** | **Location** |
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| **Responsibility** | 1 | | |
|  | 2 | | |
|  | 3 | | |
|  |  |  |  |
| **Responsibility** | 1 | | |
|  | 2 | | |
|  | 3 | | |
|  |  |  |  |
| **Responsibility** | 1 | | |
|  | 2 | | |
|  | 3 | | |

\*Please attach additional pages if necessary

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| **SOCIAL AND COMMUNITY INVOLVEMENT** | | | | |
| List professional, societal, fraternities or other organizations in which you now hold membership or in which you have been active in the past. (Indicate if you have held an elective office): | | | | |
| **Date** (dd/mm/yy) | **Position** | **Institution/Organization** | **Location** | **Responsibility** |
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| **ARTICLES/BOOKS/UNPUBLISHED PAPERS/THESIS\*** | | | | |
| List your writings either published or not published. If the work is in a language other than English, please translate the title into English and include both original and English translation. Do not include the copy of the work along with the application. | | | | |
| **Year** | **Title of publication** (Original and English) | **Subject/Topic** | **Type** | **Publisher** |
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\*Please attach additional pages if necessary.

**STUDY OBJECTIVE**

**This section is very IMPORTANT :** As part of the evaluation of your application, you are required **to attach one page (please do not exceed the page limit) of a clear and detailed description of your study objectives**. Give your reason for wanting to pursue them. Explain how this master or doctoral program fits in with your educational background, your professional background, your future objectives, and your future involvement in addressing diseases of poverty. Please type, do not write.

Type here:

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| **IDENTIFICATION OF REFERENCES** | | | |
| List the two persons from whom we will request a letter of reference. These persons should know your work and your professional capabilities. We will directly contact these persons and ask them to submit letter of references. The letter of references should be emailed to [graduate.fk@ugm.ac.id](mailto:graduate.fk@ugm.ac.id) no later than **April 25, 2023.** | | | |
| **Name** | **Title/Position** | **Institution** | **E-mail/Phone** |
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**IDENTIFICATION OF POTENTIAL FIELD SUPERVISOR (if available)**

List the one persons from whom we may request to become field supervisor. These persons should at least have PhD qualification in related subject. We will directly contact these persons in due course to confirm their availability as field supervisor.

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| **Name** | **Title/Position** | **Institution** | **E-mail/Phone** |
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| **ABOUT US** | | | |
| How do you learn about this scholarship scheme (x) | | | |
|  **Embassy** |  **University** |  **Workplace** |  **Friend/colleague** |
|  **Website** |  **Seminar** |  **Alumni** | **Other:** |

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| **EMERGENCY CONTACT** | | |
| Provide information of a person in your home country to be notified in case of emergency. | | |
| **Name :** |  |  |
| **Relationship :** |  |  |
| **Address :** |  |  |
|  | **City:** | **Province:** |
|  | **Country:** | |
| **✆Home :** |  | **✆Mobile-phone :** |
| **E-mail:** |  |  |

**DECLARATION**

* I hereby certify that the information I have provided on this application form and in any attached materials is accurate, complete and true to the best of my knowledge and belief, and I agree to notify Faculty of Medicine, Public Health, and Nursing UGM of any changes in the above information or of any further information that might affect my eligibility for consideration as a prospective recipient of the Scholarship.
* I understand that by completing this application form there is no assurance that I will be awarded a grant.
* I understand that the scholarship offered is for the Master / Doctoral Program at Faculty of Medicine, Public Health, and Nursing UGM
* I understand I will meet all the course requirements of Faculty of Medicine, Public Health, and Nursing UGM based on the approved length of the grant awarded.
* I understand I am not permitted to engage in employment beyond the visa restriction
* I understand that I will return home upon the completion of my study
* I understand that I will not be eligible to continue my scholarship selection process while I am undergoing another scholarship selection process or another scholarship program.
* I understand that grant funds are not sufficient to cover travel or support for my family and I will make necessary arrangements for the living expenses in my country or while I am in Indonesia, if they wish to join me.
* I have no objection to publicity about my selection for this Scholarship.
* I understand that I have to follow health requirements in line with regulations of the Indonesian Government and Universitas Gadjah Mada.

**Signature**: **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty of Medicine, Public Health and Nursing UGM runs an open, merit-based competition for the grants. Applications are reviewed by Faculty of Medicine, Public Health, and Nursing UGM selection team. Those applicants who meet the minimum standards of the program are then interviewed by phone or Skype by a selection committee.

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| EMAIL THIS COMPLETED SCHOLARSHIP APPLICATION TO: |
| **The Graduate Office**  **Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada**  **Sekip Utara, Yogyakarta 55281, Indonesia**  **Email:** [graduate.fk@ugm.ac.id](mailto:graduate.fk@ugm.ac.id) |
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| APPLICATION FORM CAN BE RETRIEVED FROM: |
| **graduate.fk.ugm.ac.id** |

**Ms Yuyun Yohana**

**the Graduate Program Office, Faculty of Medicine, Public Health and Nursing, UGM**

**Telp number : (+62-274) 560300**

**e-mail : graduate.fk@ugm.ac.id**

**Website : graduate.fk.ugm.ac.id**